VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 5, 2012

Mr. Robert Simpson, Administrator
Brattleboro Retreat
Anna Marsh Lane - PO Box 803
Brattleboro, VT 05301

Provider #: 474001

Dear Mr. Simpson:

Enclosed is a copy of your acceptable plans of correction for the revisit survey conducted on **June 7, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

PRINTED: 06/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474001	A. BUILDING _____ B. WING _____	R-C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 809 BRATTLEBORO, VT 05301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS An unannounced on-site follow up survey was conducted by the Division of Licensing and Protection on 5/5/12 - 6/7/12. As a result of information obtained the following deficiencies were identified.	{A 000}	A043 482.12 GOVERNING BODY The Governing Body now ensures that the hospital staff communicates relevant information and conducts a thorough quality review and analysis of all adverse events. The Governing Body now requires and closely monitors reporting of the communication, quality review and analysis of adverse events, and monitors the performance improvement activities through a review of the Patient Safety/PI Committee meeting minutes and action plans which will be discussed during regularly scheduled meetings. As described in the corrective actions below, the Governing Body ensured immediate action including, but not limited to, comprehensive remedial education and return demonstration of competency; review and revision of policies, procedures and processes; disciplinary actions taken with staff principally involved in the adverse event; development and implementation of new tools, forms and processes to assist in identification, communication, review and analysis of adverse events. Additional actions taken by the Governing Body include: 1. In order to immediately ensure patient safety and prevent access to contraband, the hospital no longer allows current inpatients to attend off-unit meetings, including "anonymous" meetings that are also attended by the public.	
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on observations, staff interviews and record review conducted throughout the days of survey the Governing Body failed to assure an effective quality assessment and performance improvement program. The Governing Body failed to assure that hospital staff communicated relevant information and conducted a thorough quality review and analysis of an adverse event that resulted in a patient requiring emergency treatment. Refer to tags: A-263, A-267, A-276, A-287	A 043		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the	A 263		

A-043 POC Accepted 6/28/12 [illegible]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] DSW, MPH | TITLE: President + CEO | (X6) DATE: 6/27/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 802 BRATTLEBORO, VT 05301

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A 263	Continued From page 1 hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on survey findings the Condition of Participation for Quality Assessment and Performance Improvement was not met related to a failure to communicate relevant information in accordance with the facility's event reporting policy, and a failure to obtain pertinent medical information during a quality review of the medical record for one patient. These failures led to a delay in the completion of a comprehensive analysis of the cause of an adverse event and failure to identify a potential quality deficient practice. Refer to: A-0267, A-0276 and A-0287	A 263	2. Immediate disciplinary actions were taken and formal counseling provided to the Unit Medical Director and the Clinical Manager on the Tyler 1 Co-occurring Disorders unit to ensure all critical incidents including a suspicion of patients obtaining illicit opiates or other contraband have been reported to the CMO, CNO, Senior Director of Standards/Quality, and the PI/Risk Manager, in accordance with policy. Additionally, the case of the patient suffering the adverse event was referred for peer review. 3. On May 1st, 2012, the President and CEO, as endorsed by the Board of Trustees, has instituted a more formal, enhanced means of monitoring, as described below, for any critical incidents and actions taken and changes that may have global hospital wide implications. This assures that executive team leaders can ensure all areas of the hospital have been assessed and actions taken if needed. 4. The Executive Team members consisting of the CMO, CNO, VP of Operations, Senior Director of Quality has begun meeting with the Tyler 1 unit leadership team on an intensified schedule to monitor critical incidents and actions taken and changes that may have global hospital wide implications. These meetings will occur weekly and will be reassessed on a quarterly basis. 5. Additionally, Executive Team members including the CMO, CNO, VP of Operations, Senior Director of Standards/Quality and the PI/Risk Manager met with all adult unit leadership teams and then all unit leadership teams in a series of targeted daily meetings beginning on 6/8/12, 6/11/12 and 6/12/12. The meeting on 6/11/12 also included the CEO.	A-043 POC Accepted Initiated: 5/1/12 6/28/12 Completed: 6/8/12 6/11/12 6/12/12
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on staff interview and record review, after being involved in an adverse patient event, hospital staff failed to complete an incident report.	A 267		

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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A 267	Continued From page 2 as per hospital policy, to ensure such events are investigated, measured, analyzed and monitored for patient safety and quality of care for 1 applicable patient. (Patient #3) Findings include: Per record review, on 5/20/12 at approximately 9:30 AM Patient #3 was transferred to the ED (Emergency Department) of an acute care hospital with symptoms of excessive drowsiness, decreased responsiveness, with a oxygen saturation of 84% (normal oxygen level is > 95%) and a drop in blood pressure. At 11:30 AM the hospital ED notified Nurse #1 that Patient #3 became awake and responsive after the administration of intravenous Narcan (an opioid antagonist used to reverse the effects of opioids including respiratory depression, sedation and low blood pressure). Although the hospital has a process for reporting substance ingestion/overdose per Sentinel Event and Critical Incident Management and Communication (last revised 02/2012), by completing an Incident/Occurrence report, Nurse #1 failed to follow policy by not submitting an Incident Report. Nurse #1 also failed to follow hospital procedure on 5/20/12 by not reporting immediately the incident of a possible patient ingestion of opioids to the House Nursing Supervisor. Per review, Patient #3 was a voluntary admission to the hospital on 5/16/12 for treatment of his/her alcohol dependence. Past medical history includes previous dependence of opioids, however upon admission no opioids were detected via laboratory results. During the course of treatment, Patient #3 received Librium (sedative/ hypnotic/benzodiazepine) as per the Alcohol Withdrawal Assessment Guidelines. On	A 267	6. These targeted meetings provided re-education of the criticality of reporting by direct care staff members of any incidents as outlined in our policies and procedures 7. Unit leaders were asked to stress with their respective staffs the critical nature of the incident event reporting process as it allows for a systemic, hospital wide consideration in any event analysis conducted by the Quality department. 8. These meetings were also held to re-educate the unit leadership members of the need for direct communication with their supervisors and the quality department, of any critical incident and action taken as a result so that executive team leaders can ensure all areas of the hospital have been assessed and actions taken if needed. A263 482.21 QAPI The Hospital now ensures communication of relevant information in accordance with its event reporting policy. The hospital now ensures that after adverse events, staff members involved complete an incident report per policy and ensures such events are investigated, measured, analyzed and monitored for patient safety and quality of care. The Quality department now ensures that hospital staff communicates relevant information according to the incident reporting policy and that all pertinent information is in the medical record for any quality review so that a comprehensive analysis of the cause of the event will be	A-043 POC Accepted 6/28/12 QDetTosh,QN

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 853 BRATTLEBORO, VT 05301

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A 267	Continued From page 3 5/18/12 the treatment team assessed Patient #3 to be safe for increased activities on Tyler 1 and within the hospital. On the evening of 5/18/12 Patient #3 attended a public wide Alcohol Anonymous (AA) meeting held in the hospital cafeteria. After being appraised of the incident on 5/20/12 involving Patient #3, the Tyler I unit nurse manager, the medical director for Tyler I and the social worker met on 5/21/12 and made a decision to stop patients from that unit from attending the community public AA meetings. This decision was made on the premise Patient #3 may have obtained an opioid substance from a member of the public on 5/18/12 while attending the AA meeting. Although other units within the hospital allow patients to attend the AA community meetings, staff from Tyler I failed to alert the other units of the potential access of drug contraband from public attendees at the AA meeting. Per interview on 6/6/12 at 9:45 AM, the Tyler I unit manager confirmed " I should have passed it on ". As a result of not completing an Incident/Occurrence report by Nurse #1 and failure of the Nurse Manager to notify senior management, to include the Medical Director, the Interim Director of Nursing and the Chief of Operations of the decision to prohibit patients from Tyler 1 from attending the public AA meetings, the full spectrum of Patient #3's critical incident was not sufficiently investigated to assess the situation and determine what immediate interventions were required. Per interview on 6/5/12 at 3:55 PM, the Senior	A 267	conducted. This is conducted with the following actions: 1) Incident reports are now reviewed daily as part of the standing agenda of the Leadership Team Meeting that occurs each morning. On week-ends the House Supervisor and Doctor on call (DOC) will review incidents daily and ensure the Administrator on call (AOC) is made aware of all incidents. 2) Comprehensive remedial education and training to be completed by 6/28/12 has been initiated for all direct care staff, reinforcing policies and procedures related to adverse events, with return demonstration of competency via question and answer, observation and "practice" documentation. Emphasis was placed upon: a) Incident Identification, Investigation and Reporting b) Communication of Adverse Events c) Roles and Responsibilities of staff in Patient Safety, Quality and Performance Improvement Processes d) When and why to file an incident report at point of care in order to provide for an immediate review of incidents/ events and real time communication to other areas to prevent a similar event e) Notification of House Nursing Supervisor of Incident f) Beginning immediately and in order to ensure a complete and thorough Quality Analysis, action planning and monitoring of the following high risk events will begin immediately: In addition to the immediate review by staff present and the House Supervisor, 100% of code blues and transfers of patients to BMH will be reviewed on a weekly basis or more often	Initiated: 6/10/12 To be completed: 6/28/12 A-23 P.O.C. Accepted Dafleet 6/28/12

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A 267	Continued From page 4 Director of Quality and Regulatory Services, confirmed s/he was unaware of the suspicion of drug contraband at the AA meeting on 5/18/12 and Tyler #1 ' s decision to close access to AA meetings for patients. The Director further confirmed on 6/7/12 at 4:45 PM the events surrounding Patient #3 ' s emergent transfer to the ED and immediate response to Narcan should have been identified as a Critical Incident requiring a report and a complete review for patient safety concerns and quality improvement.	A 267	If needed, in a critical incident review process by the CMO or designee, the unit Medical Director, an A and E LIP and the Senior Director of Standards and Quality Management How Monitored: - 100% of open medical records were reviewed on 6/7/12 and 6/8/12 on the Tyler 1 Co-Occurring Disorders unit to review for possible unreported incidents. No unreported incidents were discovered. - A random sample of 24 charts monitored for other quality indicators will now be augmented to include the following: The possibility of unreported incidents that could lead to an adverse event not being thoroughly analyzed. Person(s) Responsible: PI/Risk Manager Senior Director of Standards and Quality A267 482.21(a)(2) QAPI QUALITY INDICATORS The hospital now ensures that after adverse events, staff members involved complete an incident report per policy and ensures such events are investigated, measured, analyzed and monitored for patient safety and quality of care. 1. Comprehensive remedial education and training has been initiated, to be completed by 6/28/12, for all direct care staff, reinforcing policies and procedures related to adverse events, with return demonstration of competency via question and answer, observation and "practice" documentation. Emphasis was placed upon: a. Incident Identification, Investigation and Reporting	A 263 POC Accepted 6/28/12 Completed: 6/7/12 6/8/12 6/28/12
A 276	482.21(b)(2)(ii) QAPI IDENTIFY IMPROVEMENT [The hospital must use the data collected to--] (ii) Identify opportunities for improvement and changes that will lead to improvement. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to identify a significant quality deficient practice and implement changes that would lead to improvement following an incident involving a patient's potential access to illicit drugs. (Patient #3) Findings include: Per interview on 6/7/12 at 4:45 the Senior Director of Quality and Regulatory Services confirmed the circumstances and events surrounding Patient #3 ' s emergent transfer to the ED of an acute care hospital on 5/20/12 should have been identified as a Critical Incident requiring a report and a complete review for patient safety concerns and quality improvement. The symptoms of excessive drowsiness, decreased responsiveness, with a oxygen saturation of 84% (normal oxygen level is > 95%) and a drop in blood pressure treated successfully	A 276		Initiated: 6/14/12 To be Completed: 6/28/12

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A 276	Continued From page 6 In the ED with Narcan, created the suspicion Patient #3, while hospitalized and medicated for Alcohol detoxification., had possibly obtained access to opioids while attending a public AA meeting. Per interview on 6/5/11 at 10:15 AM, the Director of Quality confirmed all Code Blue documentation is audited to ensure documentation is complete and procedures were followed. When Patient #3 was experiencing changes in their vital signs and level of consciousness, a Code Blue was called, staff from other units responded to the medical emergency and the patient was transferred to the ED of an acute care hospital for further evaluation and treatment. Patient #3's medical record was initially reviewed by the Director of Quality due to the Code Blue event. However, the Director further confirmed, that at the time of Patient #3 's record review pertinent medical information was missing from the record. Although an attempt had been made, by the Quality Department, to obtain the medical record from the ED where treatment had occurred, as of the date of survey that information had still not been obtained, delaying the proces for thorough analysis of the event by the facility. At the surveyor's request the ED record was obtained and revealed the ED provider's " Clinical Impression " which stated on 5/20/12: " Reversal of lethargy and hypoxia secondary to narcotic use " . A progress note states " Pt. (patient) placed - opioid titration reversal with 0.1 mg. per min. At 0.3 mg, s/he was able to breath > 10 and awakened .... " .) As a result of staff not submitting a Critical Incident Report and the lack of communication from Tyler I staff, the Senior Director of Quality	A 276	b. Communication of Adverse Events c. Roles and Responsibilities of staff in Patient Safety, Quality and Performance Improvement Processes 2. A review of all incidents, adverse events and unusual occurrences is now included at each change-of-shift report as part of clinical hand-off and in any transition communication. 3. Incident reports are now reviewed daily as part of the standing agenda of the Leadership Team Meeting. On week-ends the House Supervisor and Doctor on call (DOC) will review incidents daily and ensure the Administrator on call (AOC) is made aware of all incidents. (a) As of 6/26/12, the House Supervisors rounding on each unit and program will review and print out the online log of incidents and review with the charge nurse during rounding on each unit. (b) Rounding shall occur every 2 hours to compare incidents entered online to shift report documentation of incidents (c) House Supervisors will also verbally check in with the Charge Nurse, to ensure that incidents are entered into the online module (d) House Supervisors will proactively share pertinent information with Charge Nurses on all units in order to reduce risk across the hospital. (e) Before the House Supervisor goes off shift they will check to see if staff entered the incident. If staff have not they will require it be done before staff leave the unit. (f) The House Supervisor will compare the Incident Report Module log with shift to shift reports on each unit as a check-and-balance measure to ensure that	A 267 ROC Accepted Initiated: 6/26/12 Completed 6/28/12

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A 275	Continued From page 6 and Regulatory Services was not aware of the termination of AA meetings for patients on Tyler I. Per Discharge Summary finalized on 5/29/12 the attending physician states regarding prognosis for Patient #3 "...it is likely that s/he found some opiate at the AA meeting that s/he attended and used that while s/he was here." Even though the attending physician and the Medical Director for Tyler 1 had an awareness of Patient #3's clinical case, there was a failure to inform the hospital's Medical Director. It was not until 6/5/12, at the time of survey, the Medical Director was appraised of the circumstances. An opportunity to conduct a Peer review of the case based on the impressions of Patient #3 ' s clinical condition and outcomes also did not occur. Per Patient Safety Plan (last revised on 04/2009) "The Department Directors and clinical managers are responsible for the prevention, monitoring , identification, investigation, correction and reporting of incidents and adverse events within their area of responsibility" The nurse manager stated on the morning of 6/6/12 that s/he had not reviewed Patient #3's clinical record to ensure all documentation was complete and policies followed especially as it relates to the potential opiate ingestion/overdose of Patient #3 while under the care of staff on Tyler I. The nurse manager did not obtain written statements from staff who had attended the AA meeting on 5/18/12 with Patient #3 or were present at the time of the Code Blue incident on 5/20/12 as required per Sentinel Event and Critical Incident Management and Communication (last revised 02/2012). It was further confirmed by the Senior Director of	A 276	an incident report has been initiated for each incident. (g) The House Supervisor will include a review of all incidents in their hand-off report to the oncoming supervisor How Monitored: • 100% of incident reports are now reviewed to ensure incidents if any are appropriately identified, communicated, and investigated. o Any deficiencies will be immediately addressed. o Results are aggregated, tracked, trended, analyzed, and utilized for performance improvement, as well as reported monthly to the Patient Safety/PI Committee and to the Governing Body. • The Senior Director of Standards and Quality now meets with the PI/Risk Manager and VP of Patient Care Services on a weekly basis to review 100% of incidents reported as an additional measure to reviewing the electronic report from House Supervisor's that contain critical incidents. Person(s) Responsible: PI/Risk Manager Senior Director of Standards /Quality CNO CMO CEO Governing Body A 276 482.21 (b)(2)(ii) QAPI IDENTIFY IMPROVEMENT The hospital now identifies significant quality deficient practice(s) and implements	

A-276 POC Accepted JeDeLitsch 6/28/12

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A 276	Continued From page 7 Quality and Regulatory Services there was a failure by staff to identify how the events surrounding Patient #3 impacted patient safety on all the patient treatment units. As a result, patients from other units continued to attend the AA public meetings on and after 5/18/12. Due to the lack of prompt reporting of events related to Patient #3, and the incomplete Quality Assessment review of all pertinent information delayed the hospital's opportunity to initiate changes that would lead to improvement.	A 276	changes that lead to improvement. 1. Comprehensive remedial education, to be completed by 6/28/12, with return demonstration of competency, was initiated with all staff, including medical staff, focused on identification of significant quality deficiencies, in order to ensure that staff are fully prepared to recognize and report significant quality deficiencies and events that pose a risk to patient safety. 2. Quality indicators have been reviewed and revised to include a comprehensive review of all transfers to an emergency department. 3. Additionally any incidents that do not have the Manager's follow-up completed are sent to the respective managers and their Direct Supervisors, the VP of Patient Care and CNO and the VP of Operations for immediate rectification. The report will be reviewed the next day to ensure Incidents have the Manager's follow-up completed. This report will be sent on a weekly basis. 4. In addition to the quality reviews, an expanded multidisciplinary review of all code blues and transfers to an emergency department has been implemented on 6/20/12. a. A team including the Chief Medical Officer or designee, the unit Medical Director, an A and E LIP and the Senior Director of Standards and Quality Management or designee is now convened to conduct the incident review (s), to plan for and monitor actions, effectiveness of such actions, and to ensure communication across the hospital for prevention and quality improvement.	A-276 POC Accepted [signature] 6/28/12 Initiated: 6/20/12
A 287	482.21(c)(2) QAPI IMPROVEMENT ACTIVITIES [Performance improvement activities must track medical errors and adverse patient events,] and analyze their causes, and ... This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital's Quality Assessment and Performance Improvement failed to track and analyze an adverse patient event thereby creating a delay in appropriate response to assure patient safety. Findings include: The Quality Assessment/Performance Improvement program failed to track and analyze the causes surrounding a patient adverse event related to the possible substance ingestion/overdose. Per record review, on 5/20/12 at approximately 9:30 AM Patient #3 was transferred to the hospital with symptoms of excessive drowsiness, decreased responsiveness, with a oxygen saturation of 84% (normal oxygen level is > 95%) and a drop in blood pressure. At 11:30 AM the hospital Emergency Department (ED) notified Nurse #1 that Patient #3 became awake and responsive	A 287		

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 905 BRATTLEBORO, VT 05301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 287	Continued From page 8 after the administration of intravenous Narcan (an opioid antagonist used to reverse the effects of opioids including respiratory depression, sedation and low blood pressure). Per interview on 6/5/11 at 10:15 AM Senior Director of Quality and Regulatory Services confirmed all Code Blue documentation is audited to ensure documentation is complete and procedures were followed. When Patient #3 was experiencing changes in their vital signs and level of consciousness, a Code Blue was called and staff from other units responded to the medical emergency. This record was initially reviewed by the Director of Quality due to the Code Blue event. However, the Director further confirmed, that at the time of Patient #3 ' s record review pertinent medical information was missing from the record. Although an attempt had been made, by the Quality Department, to obtain the medical record from the ED where treatment had occurred, as of the date of survey that information had still not been obtained. This delay prevented the the Director from tracking and conducting a thorough analysis of the event. At the surveyor's request the ED record was obtained on 6/6/12 and revealed the ED provider's " Clinical Impression " which stated on 5/20/12: " Reversal of lethargy and hypoxia secondary to narcotic use ". A progress note states " Pt. (patient) placed - opioid titration reversal with 0.1 mg. per min. At 0.3 mg. s/he was able to breath > 10 and awakened .... "..) As a result of not having obtained all necessary information for analysis, the hospital's Medical Director had not been informed of the potential circumstances surrounding Patient #3's adverse	A 287	b. These reviews also focus on ensuring all aspects of care, treatment and services; complete, timely and appropriate documentation, reporting, communication; and adherence to relevant policies. c. All deficiencies are immediately addressed, tracked, trended, analyzed and used for safety, quality and performance improvement. d. Trended data is reviewed in the monthly Patient Safety/PI Committee, quarterly in the Organization Wide PI Committee, quarterly in the Quality Board Committee, and quarterly in the full board of trustees meetings 5. A QAPI Dashboard has been developed and implemented to assist in hospital-wide communication of adverse events and improvement initiatives. a. The Dashboard includes aggregated type and severity data and trends related to all incidents monitored, analyzed, communicated and measured. b. Trended data is reviewed in the monthly Patient Safety/PI Committee, quarterly in the Organization Wide PI Committee, quarterly in the Quality Board Committee, and quarterly in the full board of trustees meetings in order to measure the effectiveness of improvement efforts. How Monitored: - Review and comparison of medical records, incident logs, incident reports, deshboard data and meeting minutes. - House Supervisor and Executive Rounds focused on Q&A and monitoring of changes made for improvement. Person(s) Responsible:	Initiated: 2/1/12 A-276 P.O.C Accepted DMcIntosh 6/28/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474091	A. BUILDING _____ B. WING _____	R-C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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A 287	Continued From page 9 event. On 6/7/12, at the time of survey, the Medical Director was first appraised of the circumstances related to the Code Blue, the possible ingestion of opiates and the patient's response to Narcan while receiving treatment in the Emergency Department. A peer review analysis of causes and responses of the events surrounding Patient #3's medical treatment on Tyler I had not been conducted as of 6/7/12.	A 287	Senior Director of Standards and Quality CNO CMO CEO Governing Body A 287 421.21 (c)(2)QAPI IMPROVEMENT ACTIVITIES The hospital's Quality Department tracks and analyzes all adverse patient events to ensure patient safety.	
{A 395}	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview and record review nursing staff failed to conduct a timely and ongoing assessment of a patient medicated for the symptoms of alcohol withdrawal. (Patient #3) Findings include: Per record review, Patient #3 was admitted to the hospital for the treatment of alcohol withdrawal on 5/16/2012. The physician ordered nursing staff to medicate Patient #3 by assessing the patient utilizing a scoring process for alcohol withdrawal. Librium, an anxiolytic commonly used for symptoms of alcohol withdrawal and prescribed as a PRN (as needed), was administered to Patient #3 over a 4 day period. An assessment would include vital signs, and scoring the severity of withdrawal symptoms. This information was then provided to the nurse assigned to administer medications for the entire unit. Per review of the Medication Administration Record (MAR) Patient #3 was medicated several times with Librium, without evidence of an assessment for the	{A 395}	1. All adverse patient events are included in the hospital's Quality and Performance Improvement Indicators. 2. Every adverse event is reviewed, categorized for type and severity, reported, tracked, trended and analyzed. 3. Quality deficiencies leading to the adverse events will now be shared with all units in order to prevent recurrence and improve patient safety, quality and performance. a. Adverse events, their cause, and improvement plans are documented on the shift to shift nursing report. b. At change of shift, all incoming staff are required to listen to report. c. Critical information is also shared verbally by the Charge-Nurse during the change of shift report. d. As of 6/26/12 the House Supervisors rounding on each unit will track incidents with the online incident report module log. e. House Supervisors will ensure changes are implemented to prevent recurrences and improve patient safety, quality and performance and that these changes are now taken across all units when relevant.	3/21/12 6/28/12 A-287 P.O.C. Accepted Deficiencies Initiated: 6/26/12

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	474001	A. BUILDING _____ B. WING _____	R-C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 893 BRATTLEBORO, VT 05301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 396}	Continued From page 10 effectiveness of the drug. On 5/19/12, Patient #3 demonstrated increased symptoms of alcohol withdrawal including tremors, agitation and anxiety. Although, from 12:06 AM through 9:30 PM on that date the patient received a total of 275 mg Librium, there was no evidence nurses had reassessed him/her, following each dose administration, for symptom relief.. Per interview on 6/7/12 at 10:45 AM, the Tyler I charge nurse confirmed nursing staff who are administering the PRN Librium are not consistently reassessing each patient for the effectiveness of the medication. In addition, although Patient #3 had a physician's order for Vistaril 50 mg orally every 2 hours PRN agitation, nursing staff failed to administer Vistaril although the patient was continuing to display symptoms of ongoing agitation. In addition, the patient's physician was not consulted regarding the ongoing symptoms the patient was experiencing and whether the use of Vistaril would be advisable. Per interview on 6/7/12 at 12:25 PM when discussing how s/he assesses for the effectiveness of medications administered, the medication nurse stated there was no where on the MAR to document the effectiveness of PRN medications administered. At the top of each MAR page is printed "symptom relief, yes, no, or partial" and corresponding code "sx rel " is to be documented by staff after the administration of PRN medications. When shown evidence on the MAR where nursing is to document effectiveness of PRN medication, the medication nurse stated "That is a good point...not aware of that".	{A 396}	f. A log to track all patients that have been transferred to the emergency department has been implemented on 6/26/12. The Manager of the Medical Clinic will ensure that all relevant documentation has been received from the emergency department on return of the patient. g. The Quality department will ensure that any medical records with missing documentation from the emergency department are obtained. How Monitored: • House Supervisor rounds conducted each shift to monitor for communication of adverse events • Review of aggregate data and trends to monitor implementation and effectiveness of changes made in prevention and improvement. Person(s) Responsible: CMO CNO CEO Governing Body A 395 482.23 (b) 3 RN SUPERVISION OF NURSING CARE Nursing staff will now conduct a timely and ongoing assessment of a patient medicated for the symptoms of alcohol withdrawal.	Initiated: 6/26/12
{A 396}	482.23(b)(4) NURSING CARE PLAN	{A 396}		5/14/12

A-287 POC Accepted 6/28/12 MN

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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{A 396}	Continued From page 11 The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that nursing staff developed and kept current a nursing care plan to address each patient's needs for 1 of 10 patients in the applicable sample. (Patients #3) Findings include: Per record review on 6/6/12, nursing staff failed to revise the care plan for Patient #3 who was experiencing significant pain from an infected wisdom tooth. Per review of the care plan for Patient #3's "Master Problem List" from which problems are identified and interventions, monitoring and goals are developed, both the patient's wisdom tooth infection and persistent pain were not identified to be care planned. This was confirmed by the Tyler I nurse manager on the morning of 6/8/12.	{A 396}	1. Comprehensive remedial education and training has been initiated, to be completed on 6/28/12, for all RNs on conducting the Alcohol Withdrawal assessment and on-going reassessment. Special emphasis has been placed on using the alcohol withdrawal score to assess and reassess the medications effect and the requirement that reassessment will occur within one hour of the PRN withdrawal medication being administered. 2. The policies and procedures related to RN Alcohol Withdrawal Assessment have been reviewed and revised on 6/20/12 to now ensure that procedures are clearly established that the alcohol withdrawal score is used to assess and reassess the medications effect. Also included in the policy is the requirement that reassessment will occur within one hour of the PRN withdrawal medication being administered. This reassessment will enable the RN to determine the effectiveness of the medication. If the medication is ineffective, it will guide the RN in the decision to administer other PRN medications as ordered in the Alcohol Assessment Protocol. 4. The Medication Administration Record (MAR) for prn use of medications used in alcohol detoxification has been revised to use the alcohol withdrawal score as the measurement of both the assessment and dose indicated for administration and the reassessment of	Initiated: 6/28/12 Completed: 6/28/12 A-395 R.O.C. Accepted Completed: 6/20/12 6/28/12
{B 000}	INITIAL COMMENTS From March 18-March 21, 2012, federal contract surveyors performed a recertification survey review of the special conditions of participation for psychiatric hospitals as part of a full survey completed by the State Agency based on removal of deemed status. The facility has 149 certified beds. The census at the time of the survey was 91 patients; the sample of active patients was eight.	{B 000}		
{B 122}	482.61(c)(1)(ii) TREATMENT PLAN The written plan must include the specific	{B 122}		

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{B 122}	Continued From page 12 treatment modalities utilized. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop Master Treatment Plans (MTPs) that identified physician and nursing interventions that were individualized and specific to the treatment needs for 6 of 8 active sample patients (A7, A14, B7, C7, D2, D13, E3 and E6). Instead, the MTPs included interventions which were routine, generic discipline functions that lacked focus for treatment. This failure results in treatment plans that do not reflect a comprehensive, integrated, individualized approach to multidisciplinary treatment. Findings include: A. Record Review The sample patients' MTPs included the notation: "Who are the members of your team and how will we help you achieve your goals..." The following generic interventions were listed: 1. Patient A7 (MTP dated 3/17/12) "[Physician] will talk with you about appropriate medications, educate you on the long-term physiological effects of substance abuse/dependence, assess other psychiatric symptoms that may be impacting your recovery and will monitor your medical safety..." "[Nursing] will monitor your detox symptoms and any acute medical issues you may have, support you in participating in groups and activities."	{B 122}	the effectiveness of the medication administered. How Monitored: • A random sample review of MAR's for alcohol withdrawal and compliance with the policy and a review of the use of other medications for withdrawal in addition to benzodiazepines has been added to the daily point of care chart audit. Any deficiencies are immediately addressed, tracked, trended, analyzed and utilized for performance improvement. • The House Supervisor, CNO, and/or their designee(s) now review the MAR and a random sample of assessments in the medical record documentation each shift to ensure completion of initial and ongoing assessment. • Data is reported by the House Supervisor, CNO or designee to the monthly Patient Safety/PI Committee by the and to the Governing Board quarterly for monitoring. Person(s) Responsible: CNO Medical Director Governing Body A 396 482.23(b) (4) NURSING CARE PLAN The hospital now ensures that nursing staff develops and keeps current a nursing care plan to address each patient's needs.	A-395 POC Accepted Deficiency 6/28/12

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(B 122)	Continued From page 13 2. Patient A14 (MTP dated 3/16/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 3. Patient B7 (MTP dated 3/14/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 4. Patient C7 (MTP dated 3/3/12) "Psychiatrist] will continue to evaluate for possible adjustments or changes in medications." "[Nursing] will administer medications, assess for effectiveness, observe for side effects, review safety assignments for clinical effectiveness and assist the patient with remaining safe and provide assignments to do so as necessary." 5. Patient D2 (MTP dated 1/20/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your	(B 122)	1. Focused remedial education and training on development and documentation of the Nursing Care Plan, as part of the Multidisciplinary Treatment Plan was initiated for all Nursing Staff to be completed by 6/28/12. a. Requirements for assessment, formulation, development, implementation, progress review and revision were emphasized. b. Return demonstration of competency was assessed via documentation of example cases and review of actual plans. How Monitored: • A random sample of 24 open medical records will be monitored by the Quality department on a weekly basis for a total of 96 charts per month for identification of all active problems and that an appropriate treatment plan has been created and implemented. • Any deficiencies will be immediately reported to the Charge RN, Nurse Manager and medical Director who will rectify the deficiency immediately. Person(s) Responsible: PI/Risk Manager Senior Director of Standards/Quality CNO CMO B 122 482.61 (c.)(1)(iii) TREATMENT PLAN • On May 1st, 2012, members of the Executive leadership met with all the Inpatient unit leadership teams. Executive team members present were the CEO, CMO, CNO, Vice President of Operations, Senior Director of Quality, and Senior	Initiated: 6/28/12 Completed: 6/28/12 A-396 POC Acceptable Deficiency 6/28/12

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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{B 122}	Continued From page 14 medications." 6. Patient D13 (MTP dated 3/5/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 7. Patient E3 (MTP dated 2/23/12) "[Psychiatrist] will continue to evaluate for possible adjustments or changes to medications." "[Nursing] will administer medications, assess for effectiveness, and observe for side effects." 8. Patient E6 (MTP dated 3/11/12) "[Psychiatrist] will continue to evaluate for possible adjustments or changes to medications." "[Nursing] will administer medications, assess for effectiveness, and observe for side effects." 9. Staff Interview During an interview on 3/20/12 at 1:30p.m., the Medical Director confirmed that the treatment plans were "boilerplate" and non-specific.	{B 122}	Director of Admissions / Ambulatory and Security Services. The inpatient unit leadership teams are comprised of the unit Medical Director, Clinical Manager and Social Work Supervisor. - This meeting was held to review and provide education for the new admission assessments that trigger treatment plans and the new treatment planning process that allows for identification of all active problems and individualization of treatment plans. - All unit staff were provided education in both 1-1 individual sessions and group settings within the actual treatment teams. The new process was rolled out on May 8th, 2012. The quality department has been conducting weekly chart audits of the new process and there has been a 98% percent compliance rate noted. - The Chief Medical Officer, VP of Patient Care, VP of Operations will attend treatment team meetings to provide for proctoring and role modeling of the process to ensure all problems identified on admission and that arise during the course of treatment have a corresponding treatment plan. - 100% of staff that use the new treatment planning process will receive remedial education and have a competency evaluation performed and documented.	Completed: 5/8/12
{B 144}	482.62(b)(2) MEDICAL STAFF The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	{B 144}	How Monitored: - A random sample of 24 medical records will be monitored on a weekly basis by the Quality department for a total of 96 charts per month for identification of all active problems and that an appropriate treatment plan has been created and implemented.	

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 909 BRATTLEBORO, VT 05301

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{B 144}	Continued From page 15 This STANDARD is not met as evidenced by: Based on record review and interview, the Medical Director failed to ensure that the Master Treatment Plans for 8 of 8 active sample patients (A7, A14, B7, C7, D2, D13, E3 and E6) included individualized interventions. The interventions were non-specific and similar on all treatment plans regardless of the patients' problems. This failure results in treatment plans that do not reflect a comprehensive, integrated, individualized approach to multidisciplinary treatment. Findings include: A. Record Review Review of the sample patients' MTPs included the notation: "Who are the members of your team and how will we help you achieve your goals..." The following generic interventions were listed: 1. Patient A7 (MTP dated 3/17/12) "[Physician] will talk with you about appropriate medications, educate you on the long-term physiological effects of substance abuse/dependence, assess other psychiatric symptoms that may be impacting your recovery and will monitor your medical safety..." "[Nursing] will monitor your detox symptoms and any acute medical issues you may have, support you in participating in groups and activities." 2. Patient A14 (MTP dated 3/16/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions	{B 144}	• Any deficiencies will be immediately reported to the Charge RN, Nurse Manager and medical Director who will rectify the deficiency immediately. Person(s) Responsible: PI/Risk Manager Senior Director of Standards/Quality CNO CMO B 144 482.62(b) (2) The CMO now monitors and evaluates the quality and appropriateness of services provided by medical staff. How Monitored: • The CMO will review a random sample of medical records on a weekly basis beginning on 6/28/12 to ensure individualized interventions and identification of all active problems and that an appropriate individualized treatment plan has been created and implemented. • The CMO will review the medical record audits and any deficiencies will be addressed with the attending psychiatrist or doctor on call. Person(s) Responsible: CMO Medical Executive Committee CEO Governing Body B 148 482.62(d)(1) Nursing Services The CNO now monitors and evaluates the quality and appropriateness of services provided by medical staff. How Monitored:	Initiate: 6/28/12

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BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 933 BRATTLEBORO, VT 05301

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{B 144}	Continued From page 16 with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 3. Patient B7 (MTP dated 3/14/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 4. Patient C7 (MTP dated 3/3/12) "Psychiatrist] will continue to evaluate for possible adjustments or changes in medications." "[Nursing] will administer medications, assess for effectiveness, observe for side effects, review safety assignments for clinical effectiveness and assist the patient with remaining safe and provide assignments to do so as necessary." 5. Patient D2 (MTP dated 1/20/12) "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 6. Patient D13 (MTP dated 3/6/12)	{B 144}	How Monitored: • The CNO will review a random sample of medical records on a weekly basis beginning on 6/28/12 to ensure individualized interventions and identification of all active problems and that an appropriate individualized treatment plan has been created and implemented. • The CNO will review the medical record audits and any deficiencies with the Nurse Managers who will immediately address with their respective Nursing Staff. Person(s) Responsible: CNO CEO Governing Body	Initiate: 6/28/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 303 BRATTLEBORO, VT 05301

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{B 144}	Continued From page 17 "[Physician] will complete a psychiatric assessment, discuss medication interventions with you, monitor your symptoms and discharge you from treatment." "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 7. Patient E3 (MTP dated 2/23/12) "[Psychiatrist] will continue to evaluate for possible adjustments or changes to medications." "[Nursing] will administer medications, assess for effectiveness, and observe for side effects." 8. Patient E8 (MTP dated 3/11/12) "[Psychiatrist] will continue to evaluate for possible adjustments or changes to medications." "[Nursing] will administer medications, assess for effectiveness, and observe for side effects." B. Staff Interview During an interview on 3/20/12 at 1:30p.m., the Medical Director confirmed that the treatment plans were "boilerplate" and non-specific.	{B 144}		
{B 148}	482.62(d)(1) NURSING SERVICES The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. This STANDARD is not met as evidenced by: Based on interview and record review, the	{B 148}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474001	A. BUILDING _____ B. WING _____	R-C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{B 148}	Continued From page 18 Interim Director of Nursing failed to ensure that the Master Treatment Plans for 8 of 8 active sample patients (A7, A14, B7, C7, D2, D13, E3 and E6) included specific nursing interventions. The listed nursing interventions were generic nursing activities. This deficiency can result in the lack of an integrated focus for patient treatment and fragmented nursing care for patients. Findings include: A. Record Review 1. Patient A7: The Master Treatment Plan of 3/17/12 included the following generic nursing interventions: "nursing staff will complete a Medical Nursing Care Plan if indicated and monitor symptoms as appropriate"; "nursing staff will encourage your participation in group and unit activities" and "nursing staff will monitor detox symptoms and any acute medical issues you may have, support you in participating in groups and activities." 2. Patient A14: The Master Treatment Plan of 3/16/12 included the following generic nursing interventions: "nursing staff will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medication." 3. Patient B7: The Master Treatment Plan of 3/14/12 included the following generic nursing interventions: "nursing staff will monitor your detox symptoms and any acute medical issues you may have, support you in participating in groups and activities" and "nursing staff will complete a Medical Nursing Care Plan if	{B 148}		

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	474001	A. BUILDING _____ B. WING _____	R-C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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(B 148)	Continued From page 19 indicated and monitor your symptoms as appropriate." 4. Patient C7: The Master Treatment Plan of 3/3/12 included the following generic nursing interventions: "nursing will administer medications, assess for side effects, review safety assignments for clinical effectiveness, and assist the patient with remaining safe and provide assignments to do so as necessary" and "nursing will encourage appropriate social interactions in the milieu. During 1:1 time will help pt. identify resources and coping skills." 5. Patient D2 (MTP dated 1/20/12) "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 6. Patient D13 (MTP dated 3/6/12) "[Nursing] will monitor your symptoms and safety, encourage you to participate in unit activities and administer your medications." 7. Patient E3 (MTP dated 2/23/12) "[Nursing] will administer medications, assess for effectiveness, and observe for side effects." 8. Patient E6 (MTP dated 3/11/12) "[Nursing] will administer medications, assess for effectiveness, and observe for side effects." B. Staff Interviews	(B 148)		

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	474001	A. BUILDING _____ B. WING _____	R-C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{B 148}	Continued From page 20 During an interview on 3/20/12 at 2:30p.m., the Interim Director of Nursing and Clinical Manager agreed that nursing interventions were written similarly on all Master Treatment Plans.	{B 148}		

TOTAL P.024